day stroke/death on univariant analysis was preoperative stroke (p=0.02).
Conclusion: Rationale for CDUSS in asymptomatic patients pre CS is variable and results in high numbers receiving CEA. National Guidelines for CDUSS and CEA referral pre- CS are required.

1066: VASCULAR ALLOGRAFTS – THE UK PERSPECTIVE 2008-2012

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Introduction: Cadaveric allografts provide one alternative for conduit formation in peripheral vascular disease when autografts are unavailable and prosthetic grafts pose too great a risk. We aimed to review the use of vascular allografts in the UK to identify reasons for poor uptake.
Method: All incidences of vascular allografts in the UK were recorded. Reporting forms at time of operation, then at regular intervals, were sent to the operating surgeon. The forms recorded demographics, comprehensive management information, patient progress and professional opinion.
Results: Allografts were used on eighteen occasions, including five femoral–popliteal, three ilio–femoral and two aorto–iliac bypasses. Five are currently in situ and five have been removed. Complications included arterial infection, graft infection and severe limb ulceration. Users found allografts easy to handle and many would utilise again.
Conclusion: Vascular allografts have not gained the widespread acceptance they have been afforded in Europe. The current dismal uptake will delay the development of a solid evidence base and threaten the future of the vascular allograft tissue bank. Users reported a good experience, with the ultimate proof being repeated use by four surgeons. Will it take just one exposure to highlight the practicalities of these grafts and encourage further use?

1080: PERIOPERATIVE COMPLIANCE WITH VSGBI QUALITY IMPROVEMENT FRAMEWORK FOR MAJOR LIMB AMPUTATIONS IN A SINGLE VASCULAR CENTRE

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Aim: To determine whether our department complies with the quality improvement framework for major amputations formulated by Vascular Society of Great Britain and Ireland (VSGBI).
Methods: Retrospective audit of major limb amputations performed during 12 month period until October 2012. Case notes, theatre records and departmental vascular database were analysed and data collected using a proforma formulated upon the VSBGI guideline.
Results: 41 patients had major amputations, 30 were male, average age was 70.2 years (range 36-94). 22(54%) below-knee and 17(41.5%) above-knee amputations were performed. All patients were assessed by a vascular surgeon prior to surgery. 97%(39) procedures undertaken during normal working hours. Following the decision to amputate, 73%(30) patients underwent the procedure within 48 hours. All operating surgeons were either senior vascular registrars or performed under consultant supervision. In 71%(29) anaesthesia was administered by a senior anaesthetist. Thromboprophylaxis administered for all patients and prophylactic antibiotic therapy administered in 92%(38) of patients preoperatively. Postoperatively all patients underwent physiotherapist led rehabilitation. In-hospital mortality and 30-day mortality rates were 7.3%(3) and 9.7%(4) respectively.
Conclusion: Perioperative management of lower limb amputations according to the quality improvement framework published by VSGBI, can be undertaken in a single vascular centre with acceptable outcome results.

1149: CATHETER-DIRECTED THROMBOLYSIS IN ILIO-FEMORAL DEEP VEIN THROMBOSIS

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Aim: The importance of thrombus removal through Catheter Directed Thrombolysis (CDT) for acute ilio-femoral DVT is well recognized. The aim of this study was to review outcomes following CDT in our hospital.
Methods: A retrospective review of case notes and imaging was undertaken for all cases of CDT from January 2001 to December 2012. tPA was used and administered through the popliteal vein. Patients were thrombolysed for 24-72 hours. No patient had an IVC filter inserted prior to CDT.
Results: 20 patients (mean age 36) underwent CDT for ilio-femoral DVTs. Complete radiological clearance was achieved in 40% of patients. May-Thurners Syndrome was identified as the leading cause in 30% of patients. There was no in-hospital PE, cerebral bleeding or deaths. Minor bleeding, from the catheter or cannula site, was noted in 64% of cases. One patient developed recurrent DVT within 3 month and three beyond 3 months. One patient developed a PE 7 months post CDT.
Conclusions: In our experience, CDT is a safe and successful treatment option for ilio-femoral DVTs. Our local hospital guidelines for CDT have facilitated the process of safe selection and delivery of this treatment. Our results are in keeping with the findings of published data.

1167: THE POTENTIAL IMPACT ON CLINICAL OUTCOMES AND SERVICE PROVISION OF VARIABILITY IN ULTRASOUND MEASUREMENT OF PEAK SYSTOLIC VELOCITY IN A MULTI-CENTRE VASCULAR NETWORK

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Aims: Multi-centre snap shot assessment of peak systolic velocity (PSV) measurement utilising a high fidelity pulsatile flow stimulator. Our aim is to assess sources of variability in a multi-centre vascular network.
Methods: We assessed 12 operators, across 4 different sites, utilising a reproducible waveform generated by a high fidelity pulsatile flow simulator. Measurements of PSV with both pulsatile and continuous flow waveforms were assessed for potential sources of variability.
Results: Wide variability in measured PSV: Pulsatile waveform: mean 52.1cm/s (range 40.0 - 62.9cm/s) and continuous waveform: mean 51.2cm/s (range 41.7 - 63.3cm/s). Cross-site variability was found to be greater than intra-operator variability.
Conclusions: Sources of measurement variability include angle of insonation, sample volume, internal spectral broadening, machine type and calibration. Accurate and reproducible non-invasive grading of stenoses, monitoring of their progression, and assessment of response to treatment is crucial in managing peripheral vascular disease. The formation of regional vascular networks following the VSGBI report, 'Provision of Services for Patients with Vascular Disease', means diagnostic duplex ultrasound maybe occurring on multiple sites by multiple operators. Significant variability in duplex ultrasound assessment across different sites could lead to delayed, or mis-diagnosis of significant lesions; potentially leading to inappropriate invasive diagnostic procedures or surgical interventions.

1169: ENDOVASCULAR ANEURYSM REPAIR IN NONAGENARIANS: A SYSTEMATIC REVIEW AND COMBINED ANALYSIS

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Aim: Endovascular aortic aneurysm repair (EVAR) promises a reduced morbidity and mortality compared to open surgery, creating the opportunity for aneurysm repair in those previously considered unfit for intervention. We determine the published incidence of complications and survival after elective EVAR in nonagenarians.
Method: A systematic literature search was performed using the PubMed, EMBASE and Cochrane databases up to December 2012. Two observers independently screened search results and extracted data.
Results: Five retrospective reports were identified including 111 patients (81% male) with a mean age of 91.6 years. The mean aneurysm size was 68.6mm. Comorbidities include hypertension (81%), ischaemic heart disease (50%), peripheral vascular disease (30%) and COPD (20%). There was zero on-table mortality, 24 (22%) patients suffered perioperative medical or surgical complications and 27 (24%) had endoleaks. Mean duration of hospital stay was 4 days. Thirty-day mortality was 5%, and survival at 1-, 3- and 5-years was 82%, 56% and 17% respectively.
Conclusions: The complication rates and longer-term survival after elective EVAR in carefully selected nonagenarians appears acceptable, but is higher than reported in younger patients. The use of EVAR in this age